



# Newborn Screening Dried Bloodspot Collection Form Educational Webinar

March 9, 2017

Ashley Comer, Joyal Meyer and Katie Bentz





# Presenters

- Ashley Comer, Newborn Screening Quality Improvement Coordinator, State Hygienic Laboratory, Iowa
- Joyal Meyer, RN, MSN, ND Newborn Screening Program Director
- Katie Bentz, RN, BSN, ND Newborn Screening Program Nurse Consultant



# Redesigned Card

North Dakota


Expiration Date 2019-09-30

### North Dakota Newborn Screening Program Form

<input type="checkbox"/> Initial Screen <input type="checkbox"/> Repeat Screen		Collection Date Year    Month    Day		Collection Time (24 hour clock)		Collector		Infant's Medical Record #	
Infant's Last Name						Infant's First Name			
Infant's Birth Date Year    Month    Day		Infant's Birth Time (24 hour clock)		Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Infant's Street Address    Apartment			
City		State		Zip Code		If multiple AB ...etc		Gestational Age at Birth	
Current Weight (g)		Transfused Before Collection Any Blood Products <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Date of Last Transfusion Year    Month    Day		<input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above		<input type="checkbox"/> Check if infant is in NICU <input type="checkbox"/> Check if infant has Meconium Ileus	
Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Other Please Specify		Guardian's Last Name				Guardian's First Name			
		Guardian's Birth Date Year    Month    Day		Guardian's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Guardian's Phone Number			
Birth Mother's Maiden Name									
Ordering Health Care Provider's Last Name				Ordering Health Care Provider's First Name				Ordering Health Care Provider's Phone Number	
Ordering Health Care Provider's NPI				Facility of Birth (Name, City, State)					
Primary Care Provider's Last Name <input type="checkbox"/> Check if same as above				Primary Care Provider's First Name				Primary Care Provider's Phone Number	
Submitting Facility's Name									
Submitting Facility's Street Address									
City		State		Zip Code					

PLACE THE HL7 LABEL  
WITHIN THIS BOX

FOR SHL USE ONLY




\*1AXXXXXX\*

**DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.**

**PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY**

**AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.**

1) Do not touch sample area  
2) Do not use if damaged



- Overall appearance similar to current card – color updated to green.
- Additional fields added and arrangement of fields altered.

# Educational Material

- An educational fact sheet will be sent with the new forms.
- Can be used for orientation of new staff or refresher for current staff



# It's not just a form... It's a baby

- Filling out the newborn screening form...

- ✓ Accurately
- ✓ Completely
- ✓ Legibly

Could be a matter of life and death



- Inaccurate or missing information may adversely affect screening results and/or the ability to quickly contact the infant's care provider in the event of an abnormal screening result.
- *Any delay may put the child's health at risk.*
- The specimen submitter is legally responsible for the accuracy and completeness of the information on the newborn screening card.

Remember to remove 2<sup>nd</sup> ply for facility's records.

# Health Level 7 (HL7)

- ND Facilities do not use HL7 at this time.

North Dakota Newborn Screening Program Form										
INFANT	<input type="checkbox"/> Initial Screen	<input type="checkbox"/> Repeat Screen	Collection Date Year _____ Month _____ Day _____	Collection Time ____:____ hours:____	Collector _____	Infant's Medical Record # _____				
	Infant's Last Name _____					Infant's First Name _____				
	Infant's Birth Date Year _____ Month _____ Day _____		Infant's Birth Time (24-hour) ____:____		Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Infant's Street Address _____ Apartment _____			
	City _____		State _____		Zip Code _____		If multiple, A/B, etc. _____ Feeding Method (Check all that apply) <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above			
GUARDIAN	Current Weight (g) _____		Transferred Before Collection Any Blood Products <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Date of Last Transfusion Year _____ Month _____ Day _____		Check if Infant is in NICU <input type="checkbox"/> Check if Infant has Microchipped Invert <input type="checkbox"/>			
	Guardian's Last Name _____					Guardian's First Name _____				
	Guardian's Birth Date Year _____ Month _____ Day _____		Guardian's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Guardian's Phone Number _____					
	Guardian's Relationship <input type="checkbox"/> Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____					Birth Mother's Maiden Name _____				
SUBMITTING FACILITY	Ordering Health Care Provider's Last Name _____			Ordering Health Care Provider's First Name _____			Ordering Health Care Provider's Phone Number _____			
	Ordering Health Care Provider's NPI _____			Facility of Birth (Name, City, State) _____						
	Primary Care Provider's Last Name _____		<input type="checkbox"/> Check if same as above		Primary Care Provider's First Name _____		Primary Care Provider's Phone Number _____			
	Submitting Facility's Name _____			Submitting Facility's Street Address _____			City _____ State _____ Zip Code _____			
<div style="display: flex; justify-content: space-between;"> <div> <p>DO NOT WRITE IN THIS SPACE</p> <p>PLACE THE HL7 LABEL WITHIN THIS BOX</p> </div> <div> <p>FOR SHL USE ONLY</p> </div> </div>										

DO NOT WRITE IN THIS SPACE	
PLACE THE HL7 LABEL WITHIN THIS BOX	FOR SHL USE ONLY

- Please do not write in the box “FOR SHL USE ONLY”

# Sample Information

North Dakota Newborn Screening Program Form

☐ Initial Screen    ☐ Repeat Screen

Collection Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Collection Time (24 hour clock): \_\_\_\_\_

Collector: \_\_\_\_\_

Infant's Last Name: \_\_\_\_\_

Infant's First Name: \_\_\_\_\_

North Dakota Newborn Screening Program Form

☐ Initial Screen    ☐ Repeat Screen

Collection Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Collection Time (24 hour clock): \_\_\_\_\_

Collector: \_\_\_\_\_

Infant's Last Name: \_\_\_\_\_

Infant's First Name: \_\_\_\_\_

Infant's Birth Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Infant's Birth Time (24 hour clock): \_\_\_\_\_

Infant's Gender: ☐ M ☐ F

Infant's Street Address: \_\_\_\_\_

Apartment: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

If multiple (A, B, C, etc.): \_\_\_\_\_

Gestational Age at Birth: \_\_\_\_\_

Feeding Method (Check all that apply): ☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Current Weight (g): \_\_\_\_\_

Transferred Before Collection: ☐ Yes ☐ No

If Yes, Date of Last Transfusion: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Check if infant is in NICU: ☐

Check if infant has Meconium Plug: ☐

Guardian: ☐ Mother ☐ Other Please Specify: \_\_\_\_\_

Guardian's Last Name: \_\_\_\_\_

Guardian's Birth Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Guardian's Gender: ☐ M ☐ F

Guardian's Phone Number: \_\_\_\_\_

Birth Mother's Maiden Name: \_\_\_\_\_

Ordering Health Care Provider's Last Name: \_\_\_\_\_

Ordering Health Care Provider's First Name: \_\_\_\_\_

Ordering Health Care Provider's Phone Number: \_\_\_\_\_

Ordering Health Care Provider's NPI: \_\_\_\_\_

Facility of Birth (Name, City, State): \_\_\_\_\_

Primary Care Provider's Last Name: \_\_\_\_\_

Check if same as above: ☐

Primary Care Provider's First Name: \_\_\_\_\_

Primary Care Provider's Phone Number: \_\_\_\_\_

Submitting Facility's Name: \_\_\_\_\_

Submitting Facility's Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

DO NOT WRITE IN THIS SPACE

PLACE THE HLT LABEL WITHIN THIS BOX

FOR SHL USE ONLY

North Dakota

Expiration Date 2019-09-30

SUBMITTER FACILITY HEALTH CARE PROVIDER

## Changes

- Collection information moved to top of form
- Collection date format YYYY MM DD

Initial Screen= 1<sup>st</sup> submission

Repeat Screen= Any subsequent submissions received after the initial screen, even if 1<sup>st</sup> submission was rejected due to poor quality, early collection, etc.

# Infant Information

**Infant's Medical Record #**

**Infant's Last Name**

**Infant's First Name**

**Infant's Birth Date**  
Year Month Day

**Infant's Birth Time**  
(24 hour clock)

**Infant's Gender**  
☐ M ☐ F

**Infant's Street Address**

**Apartment**

**City**

**State**

**Zip Code**

**If multiple A, B ...etc**

**Gestational Age at Birth**

**Feeding Method (Check all that apply)**  
☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

**Current Weight (g)**

**Transfused Before Collection Any Blood Products**  
☐ Yes ☐ No

**If Yes, Date of Last Transfusion**  
Year Month Day

☐ Check if infant is in NICU

☐ Check if infant has Meconium Ileus

**North Dakota Newborn Screening Program Form**

☐ Initial Screen ☐ Repeat Screen

**Collection Date** Year Month Day

**Collection Time** (24 hours)

**Collector**

**Infant's Medical Record #**

**Infant's Last Name**

**Infant's First Name**

**Infant's Birth Date** Year Month Day

**Infant's Birth Time** (24 hour clock)

**Infant's Gender** ☐ M ☐ F

**Infant's Street Address**

**Apartment**

**City**

**State**

**Zip Code**

**If multiple A, B ...etc**

**Gestational Age at Birth**

**Feeding Method (Check all that apply)**  
☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

**Current Weight (g)**

**Transfused Before Collection Any Blood Products**  
☐ Yes ☐ No

**If Yes, Date of Last Transfusion** Year Month Day

☐ Check if infant is in NICU

☐ Check if infant has Meconium Ileus

**Guardian's Last Name**

**Guardian's First Name**

**Guardian's Birth Date** Year Month Day

**Guardian's Gender** ☐ M ☐ F

**Guardian's Phone Number**

**Birth Mother's Maiden Name**

**Ordering Health Care Provider's Last Name**

**Ordering Health Care Provider's First Name**

**Ordering Health Care Provider's Phone Number**

**Ordering Health Care Provider's NPI**

**Facility of Birth (Name, City, State)**

**Primary Care Provider's Last Name** ☐ Check if same as above

**Primary Care Provider's First Name**

**Primary Care Provider's Phone Number**

**Submitting Facility's Name**

**Submitting Facility's Street Address**

**City**

**State**

**Zip Code**

**DO NOT WRITE IN THIS SPACE**

**PLACE THE HL7 LABEL WITHIN THIS BOX**

**FOR SHL USE ONLY**

**Expiration Date** 2019-09-30

**North Dakota**

## Changes

- Current card uses the term “chart number” and new form uses MRN
- DOB format YYYY/MM/DD



# Infant Information

## continued

Infant's Medical Record # \_\_\_\_\_

INFANT	Infant's Last Name										Infant's First Name												
	Infant's Birth Date Year			Month		Day		Infant's Birth Time (24 hour clock)			Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F			Infant's Street Address							Apartment		
	City					State			Zip Code		If multiple A,B...etc		Gestational Age at Birth		Feeding Method (Check all that apply) <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above								
	Current Weight (g)			Transfused Before Collection Any Blood Products <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, Date of Last Transfusion Year			Month		Day		<input type="checkbox"/> Check if infant is in NICU		<input type="checkbox"/> Check if infant has Meconium Ileus						

North Dakota		North Dakota Newborn Screening Program Form									
INFANT	<input type="checkbox"/> Initial Screen <input type="checkbox"/> Repeat Screen	Collection Date Year _____ Month _____ Day _____	Collection Time (24 hour clock) _____	Collector _____	Infant's Medical Record # _____						
	Infant's Last Name _____			Infant's First Name _____			Infant's Street Address _____				Apartment _____
	Infant's Birth Date Year _____ Month _____ Day _____	Infant's Birth Time (24 hour clock) _____	Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F	If multiple: <input type="checkbox"/> AB ...etc <input type="checkbox"/> Gestational Age at Birth _____ <input type="checkbox"/> Feeding Method (Check all that apply) <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above							
	City _____	State _____	Zip Code _____	Current Weight (g) _____    Transferred Before Collection <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Date of Last Transition _____ Day _____    Check if Infant is in NICU <input type="checkbox"/> Check if Infant has Meconium Ictus <input type="checkbox"/>							
GUARDIAN	<input type="checkbox"/> Guardian Mother <input type="checkbox"/> Other Please Specify _____	Guardian's Last Name _____		Guardian's First Name _____		Guardian's Phone Number _____ Birth Mother's Maiden Name _____					
	Guardian's Birth Date Year _____ Month _____ Day _____	Guardian's Gender <input type="checkbox"/> M <input type="checkbox"/> F									
	Ordering Health Care Provider's Last Name _____    Ordering Health Care Provider's First Name _____    Ordering Health Care Provider's Phone Number _____ Ordering Health Care Provider's NPI _____    Facility of Birth (Name, City, State) _____										
	Primary Care Provider's Last Name _____ <input type="checkbox"/> Check if same as above	Primary Care Provider's First Name _____	Primary Care Provider's Phone Number _____								
SUBMITTER FACILITY	Submitting Facility's Name _____		DO NOT WRITE IN THIS SPACE								
	Submitting Facility's Street Address _____										
	City _____	State _____	Zip Code _____	<div>PLACE THE HL7 LABEL WITHIN THIS BOX</div> <div>FOR SHL USE ONLY</div>							
	<div>1A XXXXXXX</div> <div>8</div>										

## Changes

- Infant's street address
- List multiple births using A,B,C etc  
Only applicable for this pregnancy

# Infant Information continued

Infant's Medical Record #

**INFANT**

Infant's Last Name

Infant's First Name

Infant's Birth Date  
Year Month Day

Infant's Birth Time (24 hour clock)

Infant's Gender  
☐ M ☐ F

Infant's Street Address

Apartment

City

State

Zip Code

If multiple A, B, etc

Gestational Age at Birth

Feeding Method (Check all that apply)  
☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Current Weight (g)

Transfused Before Collection Any Blood Products  
☐ Yes ☐ No

If Yes, Date of Last Transfusion  
Year Month Day

☐ Check if infant is in NICU ☐ Check if infant has Meconium Ileus

**North Dakota**

**North Dakota Newborn Screening Program Form**

Initial Screen ☐ Repeat Screen ☐ Collection Date Year Month Day

Collection Time (24 hour clock)

Collector

Infant's Medical Record #

Infant's Last Name

Infant's First Name

Infant's Birth Date  
Year Month Day

Infant's Birth Time (24 hour clock)

Infant's Gender  
☐ M ☐ F

Infant's Street Address

Apartment

City

State

Zip Code

If multiple A, B, etc

Gestational Age at Birth

Feeding Method (Check all that apply)  
☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Current Weight (g)

Transfused Before Collection Any Blood Products  
☐ Yes ☐ No

If Yes, Date of Last Transfusion  
Year Month Day

☐ Check if infant is in NICU ☐ Check if infant has Meconium Ileus

Guardian's Name  
☐ Guardian's Last Name ☐ Guardian's First Name

Guardian's Birth Date  
Year Month Day

Guardian's Gender  
☐ M ☐ F

Guardian's Phone Number

Birth Mother's Maiden Name

Ordering Health Care Provider's Last Name

Ordering Health Care Provider's First Name

Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI

Facility of Birth (Name, City, State)

Primary Care Provider's Last Name

Check if same as above

Primary Care Provider's First Name

Primary Care Provider's Phone Number

Submitting Facility's Name

Submitting Facility's Street Address

City

State

Zip Code

Expiration Date 2019-09-30

HL7 to SHL Transfer Instructions

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY

## Changes

- Feeding method options changed
- Transfusion date format YYYY MM DD

# Infant Information continued

Infant's Medical Record #

INFANT	Infant's Last Name										Infant's First Name											
	Infant's Birth Date Year    Month    Day			Infant's Birth Time (24 hour clock)			Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F				Infant's Street Address										Apartment	
	City						State		Zip Code		If multiple A,B ...etc		Gestational Age at Birth		Feeding Method (Check all that apply) <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above							
	Current Weight (g)			Transfused Before Collection Any Blood Products <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Date of Last Transfusion Year    Month    Day			<input type="checkbox"/> Check if infant is in NICU		<input type="checkbox"/> Check if infant has Meconium Ileus										

North Dakota Newborn Screening Program Form

Initial Screen ☐ Repeat Screen ☐ Collection Date Year    Month    Day    Collection Time (24 hour clock)

Infant's Last Name    Infant's First Name    Infant's Medical Record #

Infant's Birth Date Year    Month    Day    Infant's Birth Time (24 hour clock)    Infant's Gender ☐ M    ☐ F    Infant's Street Address    Apartment

City    State    Zip Code    If multiple A,B ...etc    Gestational Age at Birth    Feeding Method (Check all that apply)  
☐ Breast Milk    ☐ Formula    ☐ TPN    ☐ None of the above

Current Weight (g)    Transfused Before Collection Any Blood Products ☐ Yes    ☐ No    If Yes, Date of Last Transfusion Year    Month    Day    ☐ Check if infant is in NICU    ☐ Check if infant has Meconium Ileus

Guardian ☐ None    ☐ Other Please Specify    Guardian's Last Name    Guardian's First Name    Guardian's Birth Date Year    Month    Day    Guardian's Gender ☐ M    ☐ F    Guardian's Phone Number    Birth Mother's Maiden Name

Ordering Health Care Provider's Last Name    Ordering Health Care Provider's First Name    Ordering Health Care Provider's Phone Number    Ordering Health Care Provider's NPI    Facility of Birth (Name, City, State)

Primary Care Provider's Last Name    ☐ Check if same as above    Primary Care Provider's First Name    Primary Care Provider's Phone Number

Submitting Facility's Name    Submitting Facility's Street Address    Submitting Facility's City    State    Zip Code

Expiration Date 2019-09-30

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY

## Changes

- NICU box moved
- Meconium Ileus box added

# Submitter Information

**SUBMITTING FACILITY**

Submitting Facility's Name

Submitting Facility's Street Address

City State Zip Code

North Dakota Newborn Screening Program Form

Initial Screen ☐ Repeat Screen ☐ Collection Date Year Month Day Collection Time (24 hours) Infant's Medical Record#

Infant's Last Name Infant's First Name

Infant's Birth Date Year Month Day (24 hours) Infant's Gender ☐ M ☐ F Infant's Street Address Apartment

City State Zip Code If multiple A/B, etc Gestational Age at Birth Feeding Method (Check all that apply)

Current Weight (g) Transferred Before Collection ☐ Yes ☐ No If Yes, Date of Last Transfusion Year Month Day ☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Guardian ☐ Mother ☐ Other Person (Specify) Guardian's Last Name Guardian's First Name

Guardian's Birth Date Year Month Day Guardian's Gender ☐ M ☐ F Guardian's Phone Number

Birth Mother's Maiden Name

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's Birth Facility of Birth (Name, City, State)

Primary Care Provider's Last Name ☐ Check if same as above Primary Care Provider's First Name Primary Care Provider's Phone Number

Submitting Facility's Name Submitting Facility's Street Address

City State Zip Code

PLACEMENT LABEL WITHIN THIS BOX

FOR SHL USE ONLY

Expiration Date 2019 June 30

DO NOT WRITE IN THIS SPACE

## Changes

- Facility ID's are changing in our new LIMS system so this field was removed.
- Pre-printed label with submitter name and address will be provided with forms instead to accurately identify submitter.

(1)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

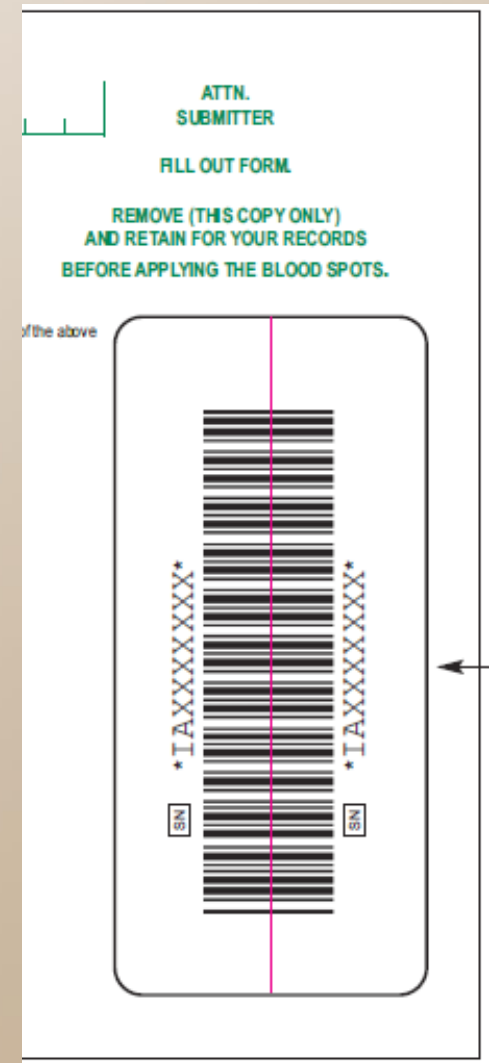
ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ IA

# Barcode Stickers

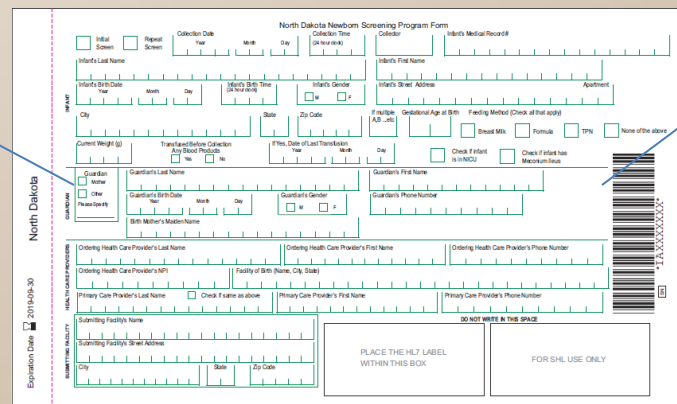
## Changes

- A sticker was added to the portion of the form that is retained by the submitting provider.
  - One half of the sticker is to be placed on the birth certificate worksheet to help ensure the proper IA number is entered.
  - The other half of the sticker should remain on the card for your facilities records.

A template for a barcode sticker. At the top, it says "ATTN. SUBMITTER" and "FILL OUT FORM". Below that, it says "REMOVE (THIS COPY ONLY) AND RETAIN FOR YOUR RECORDS BEFORE APPLYING THE BLOOD SPOTS." The main part of the sticker is a large rectangle containing a barcode. On either side of the barcode, there is a vertical line of asterisks: "\*IAXXXXXX\*" on the left and "\*IAXXXXXX\*" on the right. At the bottom of each asterisk line is a small box containing the letters "SN". A pink vertical line runs down the center of the barcode. To the right of the sticker, there is a horizontal arrow pointing left towards the sticker.

# Guardian Information

GUARDIAN	<input type="checkbox"/> Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Other Please Specify _____	Guardian's Last Name _____ _____ _____	Guardian's First Name _____ _____ _____
		Guardian's Birth Date Year _____ Month _____ Day _____	Guardian's Gender <input type="checkbox"/> M <input type="checkbox"/> F
		Birth Mother's Maiden Name _____ _____ _____	Guardian's Phone Number _____ _____ _____



North Dakota Newborn Screening Program Form

Initial Screen ☐ Repeat Screen ☐ Collection Date \_\_\_\_\_ Week \_\_\_\_\_ Day \_\_\_\_\_ Collection Time (in hour:am) \_\_\_\_\_ Infant's Medical Record # \_\_\_\_\_

Infant's Last Name \_\_\_\_\_ Infant's First Name \_\_\_\_\_ Infant's Sex \_\_\_\_\_ Infant's Date of Birth \_\_\_\_\_ Infant's Gender ☐ M ☐ F Infant's Street Address \_\_\_\_\_ Apartment \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ If multiple (M, M2, etc) \_\_\_\_\_ Gestational Age at Birth \_\_\_\_\_ Feeding Method (Check of that apply) \_\_\_\_\_ Breast Milk ☐ Formula ☐ None of the above ☐ Check if Infant has Macrocephaly ☐ Check if Infant has Microcephaly ☐

Current Weight (g) \_\_\_\_\_ Transferred Before Collection ☐ Yes ☐ No \_\_\_\_\_ Effect Date of Last Transfusion \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Guardian's Last Name \_\_\_\_\_ Guardian's First Name \_\_\_\_\_ Guardian's Birth Date \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Guardian's Gender ☐ M ☐ F Guardian's Phone Number \_\_\_\_\_ Birth Mother's Maiden Name \_\_\_\_\_

Ordering Health Care Provider's Last Name \_\_\_\_\_ Ordering Health Care Provider's First Name \_\_\_\_\_ Ordering Health Care Provider's Phone Number \_\_\_\_\_ Ordering Health Care Provider's NPI \_\_\_\_\_ Facility of Birth (Name, City, State) \_\_\_\_\_ Primary Care Provider's Last Name \_\_\_\_\_ Check if same as above ☐ Primary Care Provider's First Name \_\_\_\_\_ Primary Care Provider's Phone Number \_\_\_\_\_ Submitting Facility's Name \_\_\_\_\_ Submitting Facility's Street Address \_\_\_\_\_ Submitting Facility's City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Expiration Date ☐ 2015-09-30

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY

## Changes

- Changed section from Mother to Guardian.
  - **If biological mother is the legal guardian, please provide her information.**
- Added Box to determine relation to infant: Mother or Other Guardian.
- Added a section to capture Birth Mother's Maiden Name for birth match purposes.

# Health Care Provider Information

North Dakota Newborn Screening Program Form

Initial Screen ☐ Repeat Screen ☐ Collection Date Year Month Day Collection Time (in hours:mins) Calendar Infant's Medical Record#

Infant's Last Name Infant's First Name

Infant's Birth Date Year Month Day (in hours:mins) Infant's Gender ☐ M ☐ F Infant's Street Address Apartment

City State Zip Code If multiple ADJ (adj) Gestational Age at Birth Feeding Method (Check all that apply) ☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Current Weight (kg) Transfused Before Collection Yes ☐ No ☐ If Yes, Date of Last Transfusion Year Month Day ☐ Check if Infant is INCCU ☐ Check if Infant has Medication Error

Guardian's Last Name Guardian's First Name

Guardian's Birth Date Year Month Day Guardian's Gender ☐ M ☐ F Guardian's Phone Number

Birth Mother's Maiden Name

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI Facility of Birth (Name, City, State)

Primary Care Provider's Last Name ☐ Check if same as above Primary Care Provider's First Name Primary Care Provider's Phone Number

Screening Facility's Street Address City State Zip Code

Expiration Date 2019-09-30

PLACE THE HLT LABEL WITHIN THIS BOX

FOR SHL USE ONLY

HEALTH CARE PROVIDERS

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI Facility of Birth (Name, City, State)

Primary Care Provider's Last Name ☐ Check if same as above Primary Care Provider's First Name Primary Care Provider's Phone Number

## Changes

- Fields for both Ordering Health Care Provider AND Primary Care Provider
- Ordering Health Care Provider Number (NPI)

<https://npiregistry.cms.hhs.gov/>

# Health Care Provider Information

North Dakota Newborn Screening Program Form

Initial Screen ☐ Repeat Screen ☐ Collection Date Year Month Day Collection Time (in hours:mi) Calendar Infant's Medical Record#

Infant's Last Name Infant's First Name

Infant's Birth Date Year Month Day (check one) ☐ M ☐ F Infant's Birth Address Apartment

City State Zip Code If multiple ADJ (adj) Gestational Age at Birth Feeding Method (check all that apply) ☐ Breast Milk ☐ Formula ☐ TPN ☐ None of the above

Current Weight (g) Transferred Before Collection Yes ☐ No ☐ If Yes, Date of Last Transition Year Month Day ☐ Check if Infant is INCCU ☐ Check if Infant has Medication Issue

Guardian's Last Name Guardian's First Name

Guardian's Birth Date Year Month Day ☐ M ☐ F Guardian's Phone Number

Birth Mother's Maiden Name

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI Facility of Birth (Name, City, State)

Primary Care Provider's Last Name ☐ Check if same as above Primary Care Provider's First Name Primary Care Provider's Phone Number

Standing Facility's Street Address City State Zip Code

PLACEMENT LABEL WITHIN THIS BOX FOR SHL USE ONLY

Expiration Date 2019-03-30

HEALTH CARE PROVIDER'S

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI Facility of Birth (Name, City, State)

Primary Care Provider's Last Name ☐ Check if same as above Primary Care Provider's First Name Primary Care Provider's Phone Number

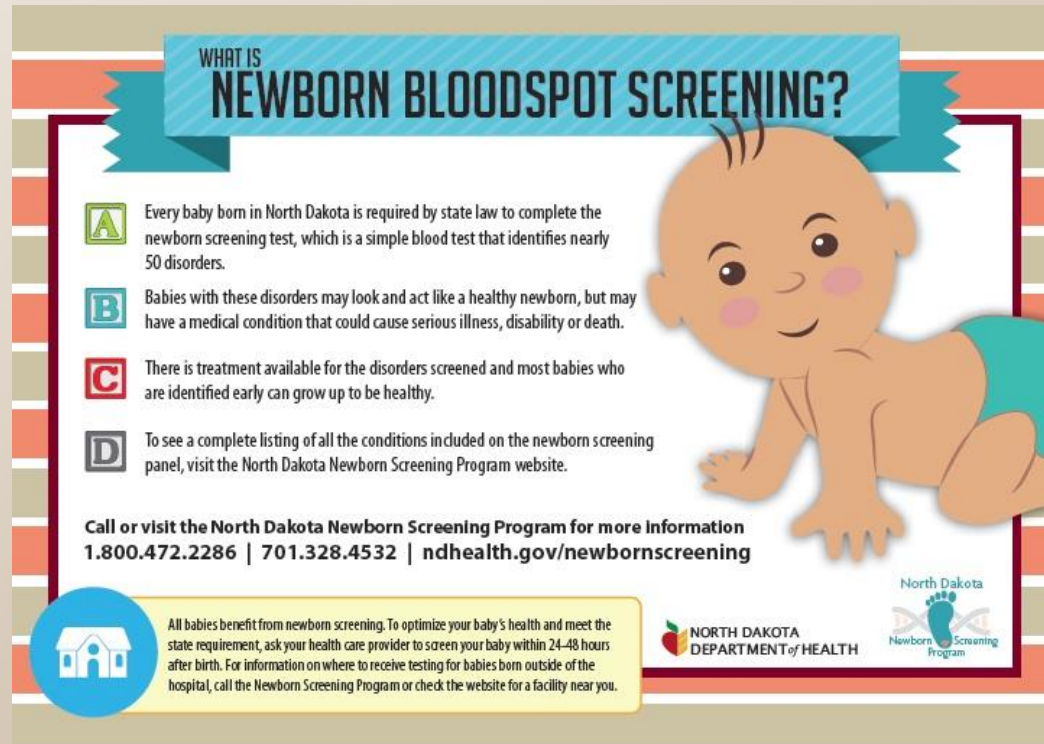
**The NBS program requests PCP information if known at time of collection.**

During education to parents about newborn screening or before the sample is collected, please ask the guardian who or where they plan on taking the newborn to for their first well check visit.



# Education

- Before a newborn screen is obtained, the parent or guardian should be educated on:
  - The type of specimen
  - How it is obtained
  - Disorders screened for
  - Consequences of treatment and non-treatment
  - Retention, use, and disposal of residual specimens



ND Newborn Screening Program brochures are available at <https://nbs.health.nd.gov/>

**Newborn screening educational resources are available to assist in education.**

One Foot at a Time Video <http://savebabies.org/video.html>

# Refusals



## REFUSAL OF NEWBORN BLOOD SPOT SCREENING TEST NORTH DAKOTA DEPARTMENT OF HEALTH DIVISION OF FAMILY HEALTH-NEWBORN SCREENING PROGRAM SFN 60025 (8-2016)

### What is Newborn Bloodspot Screening?

Every baby born in North Dakota (ND) is required by law to complete the newborn screening blood spot test; however, the parent/guardian may refuse. The test is done by taking a few drops of blood from a baby's heel, placing it on a dried blood spot card, and sending it to the laboratory for the testing of nearly 50 disorders.

Babies with these disorders may look and act like healthy newborns, but may have a medical condition that could cause serious illness, disability, or death. By the time symptoms appear, permanent damage may have already occurred.

Treatment is available for the disorders screened and most babies who are identified early can grow up to be healthy.

After testing, the blood spot cards are returned to the ND Department of Health for storage and destroyed after the child turns 18 years old. If there are concerns about storing the blood spot card, you may request the card be returned to you by contacting the ND Newborn Screening Program.

### Parent/Guardian Acknowledgments:

I have been informed about newborn blood spot screening and have read and received written information about the test.

I have discussed this screening with my provider and I accept all responsibilities for the possible outcomes to my baby for refusing the newborn blood spot screening test.

I do not want my baby screened for these disorders.

Reason for Refusal (optional)
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Name of Baby (First, Middle, Last)		Date of Birth	
Name of Parent/Guardian (First, Last)	Relationship to Baby	Telephone Number	
Parent/Guardian Mailing Address	City	State	ZIP Code

Place of Baby's Birth (Name of Facility, Hospital, or Home)			
Mailing Address	City	State	ZIP Code
Name of Provider Present at Birth (First, Last)	Title of Provider (i.e. Physician or Midwife)	Telephone Number	
Health Care Provider for Baby Following Birth (First, Last)	Name of Facility		

Parent/Guardian Signature	Printed Name	Date
Witness Signature	Printed Name	Date

**Original:** Baby's Medical Record

**Copy:** Parent/Guardian

**Copy:** North Dakota Newborn Screening Program  
Division of Family Health  
North Dakota Department of Health  
600 East Boulevard Ave., Dept. 301  
Bismarck, ND 58505-0200

**Fax:** 701.328.1412

This refusal form must be sent to the ND Department of Health within six days after testing was refused.


For questions regarding the newborn blood spot screening test or for more information call 701.328.4532 or 1.800.472.2286 or visit [www.ndhealth.gov/newbornscreening](http://www.ndhealth.gov/newbornscreening)

- Parents/Guardians are allowed to refuse the newborn screen under ND law.
- Prior to refusal, education on the testing should be provided.
- Families are required to complete the "Refusal of Newborn Blood Spot Screening Test" form.
  - Once the testing is refused, the form should be completed and returned to the program within 6 days.

<https://nbs.health.nd.gov/materials-resources/files/brochure/refusalform/>

# Return of Specimen

- Families may request to have the specimen returned to them as an alternative to refusing testing.
- A Request for Access of PHI must be completed and returned to the program to have the specimen returned.
  - Providers can place a notification with the specimen when sending it to the lab to help flag the form to expedite the process of returning it.

 <b>REQUEST FOR ACCESS OR COPY OF PROTECTED HEALTH INFORMATION</b> <small>ND Department of Health SFN 53812 (10-03)</small>			
<small>Use this form to request to inspect or receive a copy of your protected health information the NDDoH maintains. Please complete this form in its entirety. Contact the NDDoH Privacy Officer at 701.328.2352 if you have questions in relation to this request. Return this form to: Health Resources Section, Attention: Privacy Officer, ND Department of Health, 600 East Boulevard Ave., Dept. 301, Bismarck, ND, 58505-0200.</small>			
Name _____			
Street Address _____		City _____	State _____ Zip Code _____
Telephone Number _____			
Date of Birth _____			
Date of Request _____			
<b>Description of Records Requested:</b> <small>Please describe the specific information or records requested. Please also include the time period.</small>			
<b>Scope of Request:</b> <small>There is a cost-based charge for copying records. Please see page 2, General Information, for details.</small>			
<input type="checkbox"/> I would like to inspect the requested records. <input type="checkbox"/> I would like to obtain a copy of my requested records. <input type="checkbox"/> I would like to both inspect and copy the requested records. <input type="checkbox"/> Other _____			
Signature of Individual or Personal Representative _____ Date _____ <small>(If Personal Representative, please provide proof of identity and/or describe authority):</small>			
<hr/> <b>To be completed by NDDoH Privacy Officer</b>			
Identity of individual has been verified: <input type="checkbox"/> Yes <input type="checkbox"/> No		Response Due Date _____	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Delayed			
Comments: _____			
Signature of Privacy Officer _____		Date _____	
Copy to NDDoH Division Program File		Copy to HIPAA Coordinator	



# Coming soon...

## Monthly Webinar Series from the ND Newborn Screening Program

### Topics include:

- NBS Website/Resources
- NBS Stories from families
- Facility Reports/Navigate through the NBS Database
- What comes after NBS for infants with disorders
- Courier Services
- History of Disorders
- Prenatal Education for NBS
- Follow-up

We want to hear from you! If you'd like to suggest a  
topic email us at [nbs@nd.gov](mailto:nbs@nd.gov)

Be on the  
lookout for info  
on the April  
webinar



# Contact Information

- Iowa State Hygienic Laboratory – 515.725.1630 for questions regarding:
  - Data entry or corrections
  - Order dried blood spot collection forms
  - Collection supplies
- Short-term Follow-up Nurses – 319.384.5097 or toll free 1.866.890.5965 for questions regarding:
  - Follow up testing on abnormal newborn screenings
  - Letters sent to providers from follow-up
- ND Newborn Screening Program – 701.328.4532 or 1.800.472.2286 for questions regarding:
  - Resources for newborn screening
  - Century Code/Legislation/
  - Refusals

# Questions

